CMHPSM Personal Health Record: Age 11-17 Years

To Be Filled Out/Completed by **Teen/Consumer**

Consumer Name: _____ DOB: _____

CRCT #: _____

Health

In general, how would you rate your health?

○ Excellent ○ Good ○ Fair ○ Poor ○ Decline to answer

How could you improve your health? _____

Do you take medications as prescribed? ○ Yes ○ No ○ Sometimes ○ Decline

Physical Activity

In the last **7 days**, how many times were you:

Physically Active for at least 20 minutes in a day

○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days

What did you do for physical activity? _____

Is there anything that keeps you from physical activity? _____

Eat 3 or more servings of fruits or vegetables in a day

○ Everyday ○ 2-6 days ○ 1-2 days ○ 0 Days

Tobacco Use

In the last **30 days:**

Have you smoked or used chew tobacco? ○ Yes ○ No

If yes, how many packs per day? _____

If yes, do you want to quit tobacco use? ○ Yes ○ No ○ Unknown ○ Decline to answer

Do you live with/ or around someone who smokes? ○ Yes ○ No

Diet

Do you have a special diet? ○ Yes ○ No

(E.g. diabetic, low salt, pureed, thickened liquids, laxatives, lactose free, gluten free, etc.)

If yes, what type of diet? _____

Do you ever intentionally vomit after eating? ○ Yes ○ No

How often? _____

Have you ever taken laxatives or diet pills to help you lose weight? ○ Yes ○ No

Do you drink caffeinated beverages? *(E.g. soda, coffee, energy drinks, etc.)*

If yes, what type: _____ How much? _____

Eating problems? ○ Yes ○ No

Explain:_____

Prevention & Sexual Activity

Have you ever been sexually active? ○ Yes ○ No ○ Decline to answer

Are you currently sexually active? ○ Yes ○ No ○ Decline to answer

If you have ever been sexually active, do you practice safe sex? ○ Yes ○ No

Method of protection?
☐The Pill ☐Male Condom ☐Female Condom ☐Diaphragm ☐IUD ☐Cervical Cap ☐ Vaginal Ring
☐Sponge ☐Implant ☐Natural Family Planning ☐Morning After Pill ☐Female Sterilization ☐ None
☐Depo shot ☐ Decline to answer

Do you have concerns regarding Sexually Transmitted Diseases?
○ Yes ○ No ○ Decline to answer
If yes, explain_____
Were you screened for HIV/AIDS?
○ 6 Mo ○ 1 year ○ 1-2 years ○ Greater than 3 years ○ Never ○ Unsure

Female Only

If female, age when menstrual period started: _____
Any problems? ○ Yes ○ No If *Yes*, explain: _____
If you are female, could you be pregnant? ○ Yes ○ No ○ Decline to answer
Date of Last Menstrual Period _____ ☐ Not Sure

Readiness to Change

(Small everyday changes can have a big impact on your health. Think about changes you would be most interested in making over the next year. Look at the list below and choose one or more):

☐ Exercise regularly
☐ Eat Healthy
☐ Lose weight
☐ Gain weight
☐ Cut back/quit smoking or using tobacco
☐ Get an annual Flu shot
☐ Attend annual doctor and specialist appointments, following up as needed
☐ Cut back or quit drinking alcohol/substances
☐ Seek treatment for Substance Use
☐ Commit to keeping up all healthy things I do now
☐ Other:_____
☐ Decline to respond